PERSONNEL RESEARCH SERIES

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CRITICAL REQUIREMENTS OF PERFORMANCE
FOR AUDITORS AND SPECIAL AGENTS

George W. Mayeske

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Personnel Research Staff

Office of Personnel

United States Department of Agriculture

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Preface

This report is one of a series dealing with the critical performance requirements for different occupational groups.

The author gratefully acknowledges the subject matter advice and technical assistance of the following men in conducting the analyses:

John H. Adams, Jr., Office of the Inspector General
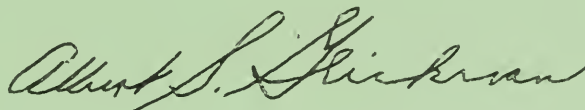
Glen A. Fast, Office of the Inspector General

The technical aspects of this study are contained in technical appendices which are available from the research files upon request.

SUMMARY AND HIGHLIGHTS

This report describes the critical incident method of determining the performance requirements for auditors and special agents and for developing a personnel performance information system for these occupations. The advantages of using performance records as source documents for many kinds of personnel actions are explained. Various ways in which management can use the information contained in pools of critical incidents to aid decision-making in such areas as career programming, spotting training needs, evaluating the relevance of training courses, and appraising the effects of program and policy changes are also illustrated.

Chief, Personnel Research Staff

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Critical Requirements of Performance
for Auditors and Special Agents

To answer the question, "How are we doing," management depends upon the adequacy of its performance information system. In any occupational area, if we have inadequate information about the requirements for satisfactory performance and the achievement of these requirements, we cannot tell how well we are doing.

During the past three years the Personnel Research Staff of the U. S. Department of Agriculture has been doing research aimed at improving our performance information systems. The following is a study of critical performance requirements for the Audit and Investigation personnel of the Office of the Inspector General (OIG).

We started with the question: "What are the critical requirements of performance in this occupation?" We got the facts by going to the people directly involved in doing and in supervising the work. We asked each of them to describe critical incidents that they had observed.

What are critical incidents?

Critical incidents are specific actions or behaviors that have actually been observed. They do not involve personality labels or lists of traits. An effective critical incident leads to significantly better than average accomplishment of a particular aspect of a job, assignment, or responsibility. An ineffective incident leads to significant delay, mistakes, omissions, or lack of accomplishment. One might say that an incident is called critical because it makes a real difference. The judgments are based upon results--the outcomes of peoples' actions and behaviors and the products of their work. They are judgments made by people at various levels, but always by the people in the best position to observe: those closest to the operational situation, those best situated to base their judgments upon the objective facts, within human limits of perceptual fallibility.

An individual critical incident is not an evaluation of a person. It is an observation of "what happened," what action took place, and what its consequences were.

Each person was asked to write up eight incidents--two effective and two ineffective incidents involving "job or technical competence" and two of each kind involving "working with people." Altogether we collected about 3000 critical incidents from Audit and Investigation personnel. To help in carrying out statistical studies of group data; we also asked for certain identifying information, but complete individual anonymity was assured.

Determining critical performance requirements

After the incidents had been collected, we sorted them into groups, according to the different critical performance requirements that they reflected. There were no predetermined categories. Sixty-nine critical requirements grew out of the content of the incident pool. There were slightly more of these requirements for the ineffective than for the effective categories.

The related critical requirements were then grouped together to identify eight critical performance areas. We tested our classification for objectivity by having two observers independently sort a sample of incidents. The agreement among observers was about 74%, which was deemed sufficient for the purposes of the study. This procedure yielded eight performance areas.

The performance record

A copy of the form developed for Audit and Investigation personnel in OIG is presented in Exhibit 1. It is organized by performance areas. Within each performance area the related critical requirements are listed--effective behaviors on the left side, ineffective on the right. Spaces are provided under each performance area for the supervisor to make notes of critical incidents at the time they occur. He will have a Performance Record for each of his subordinates.

Experience in industry has shown that on the average, supervisors of groups of up to thirty employees need no more than five minutes a day to make entries for the whole group. This is so for two reasons. First, most of the things that employees do fall within the broad range of normal, average, typical, satisfactory, or acceptable performance. Critical incidents that "make a real difference" are rarer. Just a few employees are likely to be involved on any given day. Some days there may be none. Secondly, most of the basic descriptive material is already in the Performance Record. A short note in the appropriate performance area is all that is needed to insure that the information will not be forgotten and the incident can be recalled later on.

Suppose, for example, an Auditor failed to include in his workpaper sufficient information to support his findings. Consequently the papers had to be returned to the Auditor for the additional information and reviewer time was lost. Such an incident falls in performance area 1, "Performing Technical Aspects of Assignments." Within that area the incident fits under d, on the right hand side of the page. As to "What Happened," the supervisor might merely note "No workpaper detail on audit X, returned," which should be enough to recall the incident to his mind at some later time.

Exhibit 1

I.   CARRYING OUT ASSIGNMENTS

1. PERFORMING TECHNICAL ASPECTS OF ASSIGNMENTS

A. Recognized inadequacy in procedures. B. Detected impropriety not previously disclosed by audit. C. Noted peculiarity and followed through. D. Followed through on finding. E. Provided complete yet concise support for findings. F. Accomplished assignment with limited experience or guidance. G. Obtained assistance when needed. H. Wrote report exceptionally well.

a. Did not make proper verification (factual or numerical). b. Did not detect and/or follow through on finding. c. Did not properly select sample or extend test. d. Did not properly write up support of findings or make adequate notes. e. Did not properly organize work papers and/or report. f. Did not follow proper techniques of interview. g. Did not request assistance when needed.

DATE	ITEM	WHAT HAPPENED	DATE	ITEM	WHAT HAPPENED
			3/8	d	No workpaper
					detail on audit
					X, returned

2. ASSUMING RESPONSIBILITY AND RESPONDING TO NEED FOR EXTRA EFFORT

A. Thoroughly prepared for assignment. B. Initiated steps to improve on-job performance. C. Went beyond scope of normal responsibilities (went into greater detail). D. Devised short-cut procedure for obtaining information. E. Devised new or simplified procedure. F. Demonstrated alertness and/or follow-through in unusual circumstances.

a. Did not adequately prepare for assignment. b. Lacked knowledge of program procedures. c. Did not recognize essentials of assignment. d. Did not recognize significance of information obtained. e. Did not report significant finding. f. Used too much time in preparation of work papers. g. Did not maintain proper personal appearance.

DATE	ITEM	WHAT HAPPENED	DATE	ITEM	WHAT HAPPENED

II. WORKING WITH OTHERS

3. RELATIONSHIP WITH AUDITEES AND INTERVIEWEES

A. Gained confidence or cooperation. B. Extended consideration. C. Overcame hostility. D. Obtained good acceptance of findings. E. Explained purpose of procedures. F. Pursued assignment under adverse conditions.

a. Did not gain confidence. b. Did not extend consideration. c. Was discourteous or argumentative. d. Alienated or antagonized. e. Did not adequately explain findings. f. Became personally involved with personnel. g. Was too friendly and casual or too aloof.

DATE	ITEM	WHAT HAPPENED	DATE	ITEM	WHAT HAPPENED
7/1	D	Audit Z findings			
		presented so that			
		auditee was coopera-			
		tive and interested			
		in following through			

4. COOPERATING AND GETTING ALONG WITH OTHERS

A. Coordinated with another individual or group. B. Remained pleasant and tactful under provocation.

a. Did not coordinate with another individual or group. b. Argued with or antagonized a fellow employee. c. Made inadequate group presentation.

DATE	ITEM	WHAT HAPPENED	DATE	ITEM	WHAT HAPPENED

III. MANAGING WORK AND SUPERVISING OTHERS

5. PLANNING AND ORGANIZING WORK

A. Organized for efficient use of personnel.

a. Did not delegate responsibility. b. Did not properly plan for requirements of situation.

DATE	ITEM	WHAT HAPPENED	DATE	ITEM	WHAT HAPPENED

6. MOTIVATING SUBORDINATES

A. Gave recognition for superior skill or job performance. B. Criticism was specific and constructive. C. Extended consideration for employee's personal problems or feelings. D. Gave encouragement by showing interest in employee's work or welfare.

a. Did not discuss subordinate's performance with him. b. Was not constructive or was unduly severe with criticism. c. Did not extend consideration to employee's personal problems. d. Acted in arbitrary or dictatorial manner. e. Criticized in presence of others.

DATE	ITEM	WHAT HAPPENED	DATE	ITEM	WHAT HAPPENED

7. TRAINING AND DEVELOPING SUBORDINATES

A. Provided information when needed. B. Gave help or training when needed. C. Explained specific requirements of job.

a. Did not provide guidance or training when needed. b. Did not explain specific requirements of job.

DATE	ITEM	WHAT HAPPENED	DATE	ITEM	WHAT HAPPENED

8. MAINTAINING COMMUNICATIONS

A. Explained reason for decision affecting employee.

a. Did not explain reason for decision affecting employee. b. Did not clarify or answer questions. c. Did not provide information when needed. d. Gave improper and/or incomplete instructions. e. Did not give subordinate an opportunity to explain.

DATE	ITEM	WHAT HAPPENED	DATE	ITEM	WHAT HAPPENED

Again, suppose that the employee's performance record showed the following entry under 3D: "Audit Z findings presented so that auditee was cooperative and interested in following through." The statement of critical requirement 3D will serve to remind the supervisor that in this incident the Auditor sensed that the auditee was nervous and disagreeable about the exit interview and hence phrased the findings in a manner that was effective but non-offensive. As a result the auditee was cooperative and interested in taking corrective action on the findings. In both examples the relevant information is neatly summarized in a single short phrase.

PUTTING CRITICAL INCIDENTS TO WORK

Personnel performance information for decision-making

Up to this point we have concentrated upon providing an understanding of what critical incidents are, and how they are used to define the critical performance requirements of an occupation and to develop a performance record. Hopefully, experienced managers among our readers have begun to perceive the applicability and utility of such information at many points across a broad range of management activities.

If we consistently assemble and maintain a store of information on individuals' performance at work, we will have available the essential facts needed to arrive at any of the administrative personnel decisions we are called upon to make. The summation of the pluses and minuses of individual performance can give us an improved comprehension of the requirements that most influence success and failure in achieving our objectives. We will reduce the burden of separately maintaining large overlapping files of performance information for each administrative application (e.g. awards, transfers, promotions, annual ratings, training needs).

From here on we will explore in greater depth some specific ways supervisors and managers can make use of the critical incident technique and critical incident records.

What can critical incidents tell management?

Our answers can be developed in two areas: (1) individual supervisor-subordinate relations; and (2) general personnel management functions and programs.

Individual supervisor-subordinate relations

Accumulating information about performance in the critical require-
ments of work continually rather than intermittently, provides a more
objective record of information. The pressures to "mold" the information
are less than when it must be pulled from your head only when a report
on an individual is needed for some specific purpose This is so,
because the ends to be served by the report tend to determine what
information will be retrieved and offered on that occasion. Contrary to
good theory, the supervisor in practice usually makes his judgment first,
and then finds the "facts" to support it, instead of the other way
around. So, if all performance information is present as part of admin-
istrative reports, there remains no independent source of data collected
under "neutral" conditions.

A supervisor's note in a person's performance record is neither a
punishment nor a reward. The performance record is not an evaluation
form, nor is the supervisor attempting to evaluate the person when he
makes a note for the record. He is only evaluating the quality of a
specific action or performance. The notes are merely reminders of facts
to be considered in talking to the employee about his work, and for refer-
ence when personnel decisions are to be taken later on. They are as much
the property of the employee as of the supervisor. If the employee wants
to use these notes to improve himself, they are available for discussion
with his supervisor. The employee makes the record. The supervisor only
keeps it.

Since observations are noted when they happen, the information is
less subject to forgetting and errors of recall. Since the critical
incidents are identified with the normal work situation and discussed
when they happen, both parties are likely to develop a better balanced
perspective.

As a consequence, the significance of individual incidents is less
likely to be inflated out of all proportion to their place in the total
picture of performance.

Because the incidents deal with observable behavior and its results,
it is possible to discuss performance, and even to evaluate it on a less
emotion-provoking level than is so often the case when inability to
recall specific illustrative incidents leads to generalized and
questionable personality analysis.

Furthermore, the summaries of an individual's performance history
that underlie the evaluations and decisions needed in performance review,
career planning, promotion rosters, and training plans, are less likely

to be looked upon as bureaucratic procedures, largely divorced from the realities of day-to-day experience and the normal relations between a man and his boss. This can mean improvement not only in job performance, attitudes, and common understanding, but in the quality of supervision as well.

In these circumstances, forms and procedures are developed to facilitate the use of information, but the forms are clearly subordinated to the substance of the information system.

As a result, the occasions when formal review and evaluation take place are less likely to be regarded as uncomfortable special occasions during which both parties must communicate self-consciously, with their guards up. The "summing up" is more likely to be looked upon in a healthy fashion as the natural consequence of shared experience, and as part of a jointly held aim to further the success of the outfit of which both are a part.

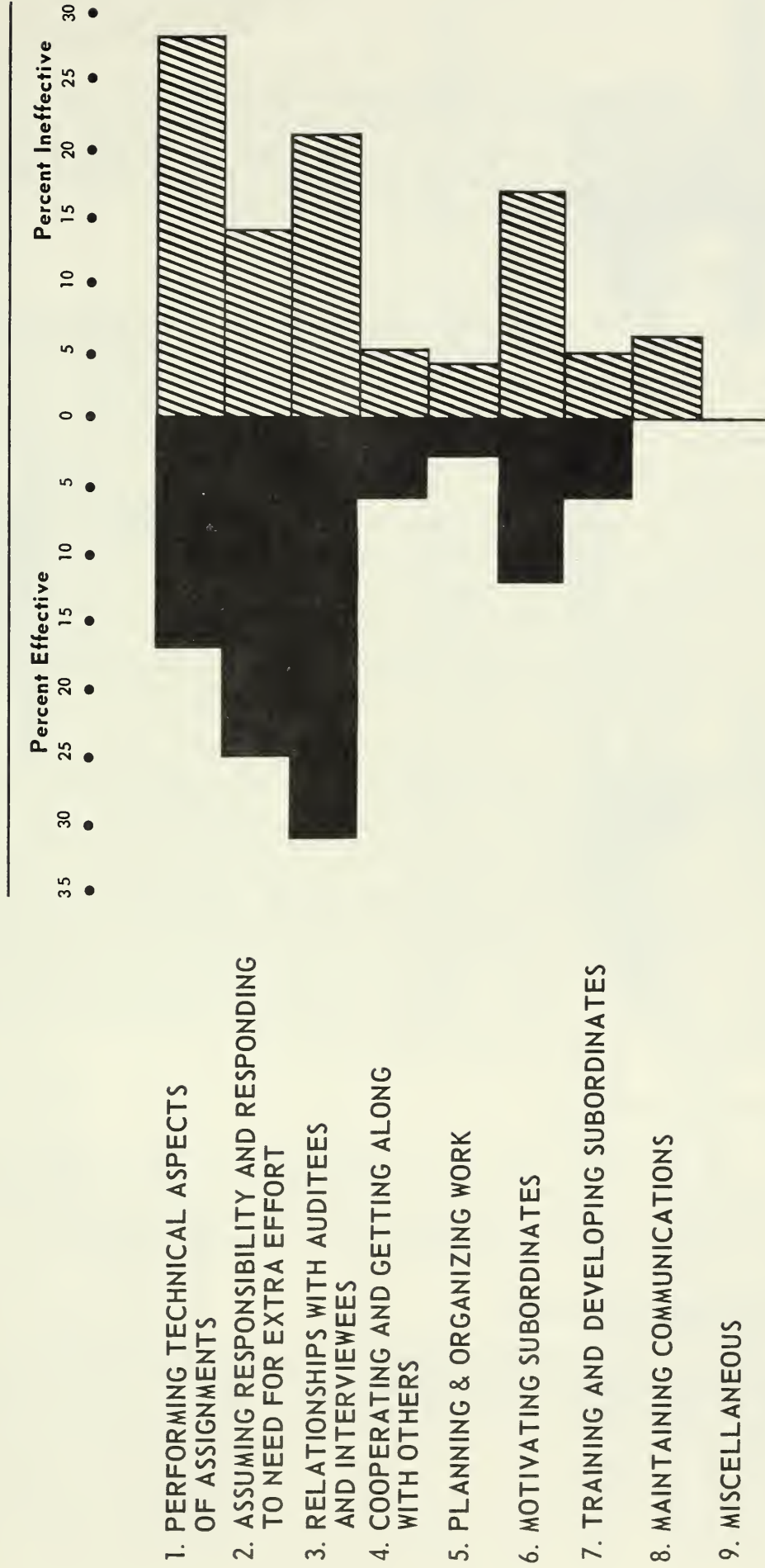## General personnel management function and programs

Apart from those situations of an individual nature, the pools of critical incidents that are accumulated offer valuable knowledge to managers. Given supplementary information on such characteristics of the groups involved as grade level, length of service, age, sex, and occupational specialty, useful comparisons can be made. Again let us look at some examples.

Taking the pulse of the organization

What are the areas of particular strength or weakness in the functioning of the organization as a whole? Consider Exhibit 2. Exhibit 2 is based upon a sample of about 1500 incidents drawn from the pool of 3000. We see that relatively high concentrations of both effective and ineffective incidents occur in the areas of "Relationships With Auditees and Interviewees," "Performing Technical Aspects of Assignments" and "Assuming Responsibility and Responding to Need for Extra Effort." However, "Performing Technical Aspects of Assignments," shows a higher concentration of ineffective than effective incidents, while the reverse is true of "Assuming Responsibility and Responding to Need for Extra Effort" and "Relationships With Auditees and Interviewees." The area of "Motivating Subordinates" also has a high concentration of effective and ineffective incidents. On the other hand, relatively few incidents of either type occur in the area of "Planning and Organizing Work."

EXHIBIT 2

PERCENT OF EFFECTIVE AND INEFFECTIVE INCIDENTS BY PERFORMANCE AREAS

Percent Effective

Percent Ineffective

35 30 25 20 15 10 5 0 5 10 15 20 25 30

1. PERFORMING TECHNICAL ASPECTS OF ASSIGNMENTS

2. ASSUMING RESPONSIBILITY AND RESPONDING TO NEED FOR EXTRA EFFORT

3. RELATIONSHIPS WITH AUDITEES AND INTERVIEWEES

4. COOPERATING AND GETTING ALONG WITH OTHERS

5. PLANNING & ORGANIZING WORK

6. MOTIVATING SUBORDINATES

7. TRAINING AND DEVELOPING SUBORDINATES

8. MAINTAINING COMMUNICATIONS

9. MISCELLANEOUS

The significance for management of a tabulation like this is obvious. It pinpoints the areas where further analysis might be profitable. Take just one example. A comparison of the distribution of critical incidents with present statements of job requirements can show whether or not the latter need to be revised.

Making promotion decisions

How do the critical requirements of the job change with grade level? Exhibit 3 shows the proportions of incidents at different grade levels for each performance area. At the lower levels, the greatest proportions of incidents involve "Performing Technical Aspects of Assignments," "Assuming Responsibility and Responding to Need for Extra Effort," and "Relationships With Auditees and Interviewees." At the higher levels, "Motivating Subordinates," "Training and Developing Subordinates," and "Maintaining Communications" account for a greater proportion of incidents than at the lower levels. At each grade level, "Relationships With Auditees and Interviewees" remains relatively high in its proportion of incidents. No surprise here. Nevertheless, an analysis of critical incidents can help to define the content and changes in work that occur at these different levels, thus providing management with more specific information than might otherwise be available.

When incidents are classified and tabulated as in Exhibit 3, it quickly appears that the supervisor may not have the opportunity to observe behaviors at one level that are indicative of how well the employee will perform at a higher level, because there may be little or no opportunity for these kinds of incidents to occur. As Exhibit 3 clearly shows, "Planning and Supervising" incidents, which preponderate at the higher grade levels occur very infrequently at the lower levels. Hence, in making a selection for a supervisory job, a promotion board might wish to supplement performance information with other data - for example, tests - to get a better prediction of how well a person might be expected to function as a supervisor.

Planning job rotation

A job rotation plan can be developed by classifying the incidents according to functional areas. This would enable participants in the plan to gain experience in certain kinds of problem situations that would enhance their performance later in their careers.

Spotting training needs

Just as an individual employee's performance record can be used to diagnose his specific training needs, so too can a pool of critical incidents collected from many employees point up training needs of the

PERCENT OF EFFECTIVE AND INEFFECTIVE INCIDENTS
BY PERFORMANCE AREAS AND GS LEVELS
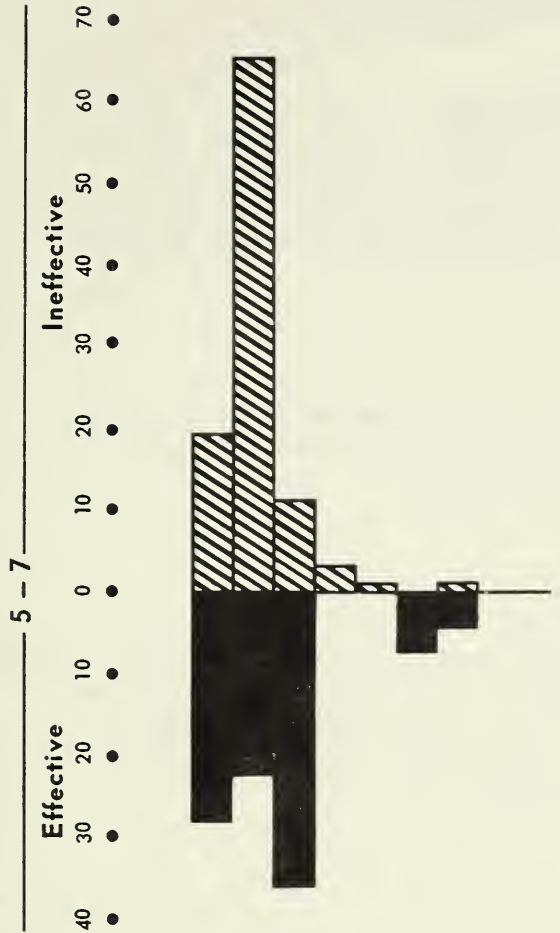
1. Performing Technical Aspects of Assignments
2. Assuming Responsibility & Responding to Need for Extra Effort
3. Relationships with Auditees & Interviewees
4. Cooperating & Getting Along with Others
5. Planning & Organizing Work
6. Motivating Subordinates
7. Training & Developing Subordinates
8. Maintaining Communications
9. Miscellaneous
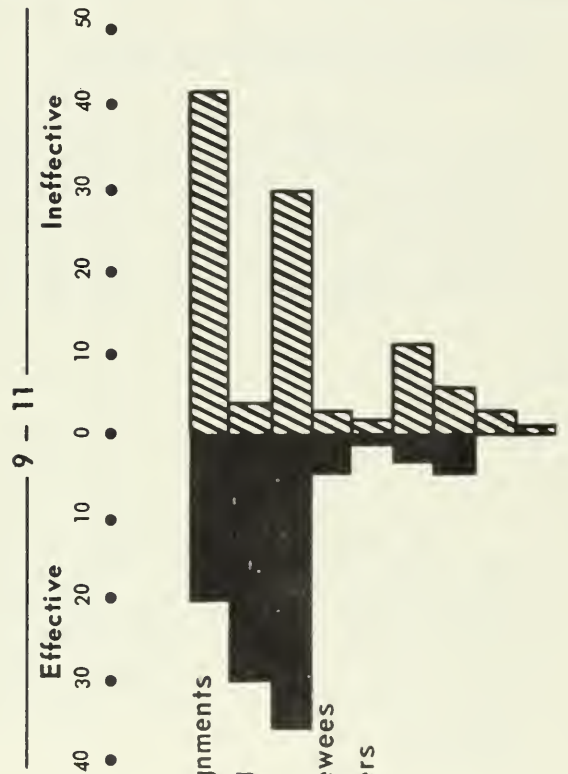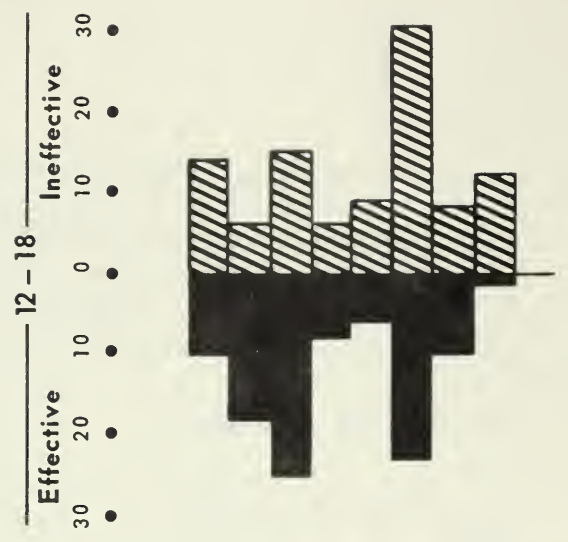
1. Performing Technical Aspects of Assignments
2. Assuming Responsibility & Responding to Need for Extra Effort
3. Relationships with Auditees & Interviewees
4. Cooperating & Getting Along with Others
5. Planning & Organizing Work
6. Motivating Subordinates
7. Training & Developing Subordinates
8. Maintaining Communications
9. Miscellaneous

group as a whole. This is particularly true when the incidents are classified according to function or program areas. Inspection of the incidents may suggest curriculum content, as for example, certain supervisory practices that need to be emphasized or re-emphasized. Indeed the incidents themselves might be incorporated as study material in a supervisory training program.

Determining relevance of training

Critical incidents can also be used to assess and validate existing curriculum content by checking them as to whether the relevant skills are "Taught" or "Not Taught" in the course.

Evaluating program changes

Still another potential use for critical incidents is the evaluation of program and policy changes. Suppose that a certain organizational or procedural change is introduced in order to alleviate some problem situation. Incidents collected after the change has been introduced can be compared with those in the present incident pool, and a statement as to the effects of the change then can be made.

CONCLUSION

It should be evident by now that critical incidents can tell management many things that it needs to know. The information derivable from an analysis of critical incidents is less influenced by subjectivity and bias, because it is based upon actually observed job performance. At the same time, it is more precise, more specific, and more relevant to the requirements of the job than information obtained by more traditional methods.